

STATE OF ILLINOIS

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Facility Name & ID Number Warren Park Nursing Pavilion# 0036079 Report Period Beginning: 01/01/04 Ending: 12/31/04

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed bedsN/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>127</u>	Skilled (SNF)	<u>127</u>	<u>46,482</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>127</u>	TOTALS	<u>127</u>	<u>46,482</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>3,965</u>	<u>47</u>	<u>1,783</u>	<u>5,795</u>	8
9	SNF/PED					9
10	ICF	<u>24,538</u>	<u>636</u>	<u>360</u>	<u>25,534</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>28,503</u>	<u>683</u>	<u>2,143</u>	<u>31,329</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 67.40%

D. How many bed-hold days during this year were paid by Public Aid?

N/A (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)N/A

F. Does the facility maintain a daily midnight census?

YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 03/10/90

J. Was the facility purchased or leased after January 1, 1978?

YES ☒ Date 3/10/90 NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter number
of beds certified 11 and days of care provided 1,360Medicare Intermediary Mutual Of Omaha

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 12/31/04 Fiscal Year: 12/31/04

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

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Facility Name & ID Number

Warren Park Nursing Pavilion

0036079

Report Period Beginning:

01/01/04

Ending:

12/31/04

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	198,199	15,780	6,720	220,699		220,699		220,699			1
2	Food Purchase		163,746		163,746	(40,754)	122,992	(36)	122,956			2
3	Housekeeping	92,821	22,419		115,240		115,240		115,240			3
4	Laundry	37,732	8,339		46,071		46,071		46,071			4
5	Heat and Other Utilities			97,587	97,587		97,587	718	98,305			5
6	Maintenance	29,292	13,304	33,776	76,372		76,372	4,877	81,249			6
7	Other (specify):*							459	459			7
8	TOTAL General Services	358,044	223,588	138,083	719,715	(40,754)	678,961	6,018	684,979			8
	B. Health Care and Programs											
9	Medical Director			4,200	4,200		4,200		4,200			9
10	Nursing and Medical Records	838,716	82,703	61,736	983,155		983,155	(25,950)	957,205			10
10a	Therapy		58	5,751	5,809		5,809		5,809			10a
11	Activities	60,684	4,553	2,044	67,281		67,281	(175)	67,106			11
12	Social Services	91,336		2,380	93,716		93,716		93,716			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	990,736	87,314	76,111	1,154,161		1,154,161	(26,125)	1,128,036			16
	C. General Administration											
17	Administrative	58,576		36,000	94,576		94,576	49,694	144,270			17
18	Directors Fees											18
19	Professional Services			300,038	300,038	(4,188)	295,850	(254,855)	40,995			19
20	Dues, Fees, Subscriptions & Promotions			23,968	23,968		23,968	(9,932)	14,036			20
21	Clerical & General Office Expenses	52,375	753	139,264	192,392		192,392	(80,913)	111,479			21
22	Employee Benefits & Payroll Taxes			255,602	255,602	40,754	296,356		296,356			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,682	1,682		1,682	358	2,040			24
25	Other Admin. Staff Transportation			1,839	1,839		1,839		1,839			25
26	Insurance-Prop.Liab.Malpractice			83,652	83,652		83,652	694	84,346			26
27	Other (specify):*							35,326	35,326			27
28	TOTAL General Administration	110,951	753	842,045	953,749	36,566	990,315	(259,627)	730,688			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,459,731	311,655	1,056,239	2,827,625	(4,188)	2,823,437	(279,734)	2,543,703			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

STATE OF ILLINOIS

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Facility Name & ID Number

Warren Park Nursing Pavilion

#0036079

Report Period Beginning:

01/01/04

Ending:

12/31/04

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			40,380	40,380		40,380	163,579	203,959			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			38,743	38,743		38,743	144,288	183,031			32
33	Real Estate Taxes			104,549	104,549	4,188	108,737	(753)	107,984			33
34	Rent-Facility & Grounds			376,671	376,671		376,671	(376,671)				34
35	Rent-Equipment & Vehicles			6,064	6,064		6,064	5,003	11,067			35
36	Other (specify):*											36
37	TOTAL Ownership			566,407	566,407	4,188	570,595	(64,555)	506,040			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		43,064	29,641	72,705		72,705	(221)	72,484			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			69,724	69,724		69,724		69,724			42
43	Other (specify):*	15,047			15,047		15,047	(15,047)				43
44	TOTAL Special Cost Centers	15,047	43,064	99,365	157,476		157,476	(15,268)	142,208			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,474,778	354,719	1,722,011	3,551,508		3,551,508	(359,557)	3,191,951			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Warren Park Nursing Pavilion

0036079

Report Period Beginning: 01/01/04

Ending: 12/31/04

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	91,998	30		9
10	Interest and Other Investment Income	(26,255)	32		10
11	Discounts, Allowances, Rebates & Refunds	(2,657)	10		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(36)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(875)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(69,356)	21		24
25	Fund Raising, Advertising and Promotional	(8,455)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(84,743)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (100,379)		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(259,178)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (259,178)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (359,557)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Report Period Beginning: 01/01/84
Ending: 12/31/84

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference
1	Bank Charges	\$ (12,019)	21 1
2	Collection Fee	(18,366)	21 2
3	PPA - Nursing Supplies	(17,449)	10 3
4	PPA - Office Expense	(3,615)	21 4
5	PPA - Equipment Rental	(250)	20 5
6	PPA - Nursing Expense	(680)	10 6
7	PPA - Medicare	(104)	39 7
8	PPA - Maintenance Expense	(669)	40 8
9	PPA - Insurance Expense	(618)	26 9
10	PPA - Activity Supplies	(175)	11 10
11	PPA - Dues, Fees & Subscriptions	(50)	20 11
12	Capitalized R&M	(1,736)	86 12
13	Cope Dues	(1,834)	20 13
14	Marketing Salary	(15,847)	42 14
15	Unit Fees (Hill Co)	(150)	20 15
16	Franchise Fee (Hill Co)	(250)	20 16
17	Non-Allowable Seminar	(60)	24 17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
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90			90
91			91
92			92
93			93
94			94
95			95
96			96
97			97
98			98
99			99
100			100
101	Total	(84,743)	101

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Warren Park Nursing Pavilion

0036079

Report Period Beginning:

01/01/04

Ending:

12/31/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary													1
2	Food Purchase	(36)											(36)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities			718									718	5
6	Maintenance	(2,036)		1,464	5,449								4,877	6
7	Other (specify):*					459							459	7
8	TOTAL General Services	(2,072)		2,182	5,449	459							6,018	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(20,786)						(5,164)					(25,950)	10
10a	Therapy													10a
11	Activities	(175)											(175)	11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	TOTAL Health Care and Programs	(20,961)						(5,164)					(26,125)	16
	C. General Administration													
17	Administrative			(36,000)	85,694								49,694	17
18	Directors Fees													18
19	Professional Services		600	(255,455)									(254,855)	19
20	Fees, Subscriptions & Promotions	(10,739)	400	407									(9,932)	20
21	Clerical & General Office Expenses	(116,232)	(84)	30,141	5,262								(80,913)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar	(60)		418									358	24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice	(610)		1,304									694	26
27	Other (specify):*			5,347		29,979							35,326	27
28	TOTAL General Administration	(127,640)	916	(253,838)	90,956	29,979							(259,627)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(150,673)	916	(251,656)	96,405	30,438		(5,164)					(279,734)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number **Warren Park Nursing Pavilion**# **0036079**

Report Period Beginning:

01/01/04

Ending:

12/31/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	91,998	69,199	2,382									163,579	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(26,255)	168,487	2,056									144,288	32
33	Real Estate Taxes		(3,300)	2,547									(753)	33
34	Rent-Facility & Grounds		(376,671)										(376,671)	34
35	Rent-Equipment & Vehicles	(298)		5,300									5,003	35
36	Other (specify):*													36
37	TOTAL Ownership	65,445	(142,285)	12,285									(64,555)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers	(104)						(117)					(221)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(15,047)											(15,047)	43
44	TOTAL Special Cost Centers	(15,151)						(117)					(15,268)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(100,379)	(141,369)	(239,371)	96,405	30,438		(5,281)					(359,557)	45

Facility Name & ID Number Warren Park Nursing Pavilion# 0036079

Report Period Beginning:

01/01/04

Ending:

12/31/04

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached		See Attached		See Attached		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 Rental Income	\$ 376,671	Warren Park LLC		\$	\$ (376,671)	1
2	V	33 Real Estate Tax Over Accrual	121,200	Warren Park LLC			(121,200)	2
3	V	33 Real Estate Tax Expense		Warren Park LLC		117,900	117,900	3
4	V	32 Interest		Warren Park LLC		168,487	168,487	4
5	V	20 Trust Fees		Warren Park LLC		150	150	5
6	V	20 Franchise Tax		Warren Park LLC		250	250	6
7	V	19 Accounting Fees		Warren Park LLC		600	600	7
8	V	21 Bank Charges	84	Warren Park LLC			(84)	8
9	V	30 Depreciation		Warren Park LLC		69,199	69,199	9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 497,955			\$ 356,586	\$ * (141,369)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **Warren Park Nursing Pavilion**# **0036079**Report Period Beginning: **01/01/04**Ending: **12/31/04****VII. RELATED PARTIES (continued)**

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	5 UTILITIES	\$	DYNAMIC HEALTH CARE CONS.	100.00%	\$ 718	\$ 718
16	V	6 REPAIRS & MAINT.				1,464	1,464
17	V	19 PROFESSIONAL FEES	256,900			1,445	(255,455)
18	V	20 DUES AND SUBSCRIPTIONS				407	407
19	V	21 CLERICAL & GENERAL				30,141	30,141
20	V	24 SEMINARS AND TRAVEL				418	418
21	V	26 INSURANCE				1,304	1,304
22	V	27 EMP.BEN. - GEN. ADMIN.				5,347	5,347
23	V	30 DEPRECIATION				2,382	2,382
24	V	32 INTEREST				2,056	2,056
25	V	33 REAL ESTATE TAXES				2,547	2,547
26	V	35 EQUIPMENT RENTAL				5,300	5,300
27	V						
28	V	17 Management Fees	36,000				(36,000)
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 292,900			\$ 53,529	\$ * (239,371)

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Warren Park Nursing Pavilion

0036079

Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	6 MAINT. CMP. - D. NEHMER	\$	DYNAMIC HEALTH CARE CONS.	100.00%	\$ 5,449	\$ 5,449	15
16	V	17 ADMIN. CMP. - M. MAUER				12,793	12,793	16
17	V	17 ADMIN. CMP. - M. AARON				14,156	14,156	17
18	V	17 ADMIN. CMP. - F. AARON						18
19	V	17 ADMIN. CMP. - S. GOLDSTEIN				18,667	18,667	19
20	V	17 ADMIN. CMP. - S. KOPLIN				8,208	8,208	20
21	V	17 ADMIN. CMP. - D. MAGAFAS				6,698	6,698	21
22	V	17 ADMIN. CMP. - S. LEVY				11,468	11,468	22
23	V	17 ADMIN. CMP. - HOWARD ALTER						23
24	V	17 ADMIN. CMP. - NON-OWNER				13,704	13,704	24
25	V	21 CLERICAL CMP. - S. AARON				5,262	5,262	25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$ 96,405	\$ * 96,405	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Warren Park Nursing Pavilion

0036079

Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	7 EMP. BEN.- D. NEHMER	\$	DYNAMIC HEALTH CARE CONS.	100.00%	\$ 459	\$ 459	15
16	V	27 EMP. BEN.- M. MAUER				1,037	1,037	16
17	V	27 EMP. BEN.- M. AARON				1,564	1,564	17
18	V	27 EMP. BEN.- F. AARON						18
19	V	27 EMP. BEN.- S. GOLDSTEIN				19,758	19,758	19
20	V	27 EMP. BEN.- S. KOPLIN				2,441	2,441	20
21	V	27 EMP. BEN.- D. MAGAFAS				631	631	21
22	V	27 EMP. BEN.- S. LEVY				1,603	1,603	22
23	V	27 EMP. BEN.- HOWARD ALTER						23
24	V	27 EMP. BEN.- NON-OWNER				2,039	2,039	24
25	V	27 EMP. BEN.- S. AARON				906	906	25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$ 30,438	\$ * 30,438	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Warren Park Nursing Pavilion# 0036079Report Period Beginning: 01/01/04Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	10A THERAPY	\$ 5,600	DYNAMIC REHAB CONSULTANTS, L.L.C.	100.00%	\$ 5,600	\$
16	V	19 PROFESSIONAL FEES	2,320	DYNAMIC REHAB CONSULTANTS, L.L.C.	100.00%	2,320	
17	V	22 EMPLOYEE BENEFITS		DYNAMIC REHAB CONSULTANTS, L.L.C.	100.00%		
18	V	39 ANCILLARY SERVICES	24,873	DYNAMIC REHAB CONSULTANTS, L.L.C.	100.00%	24,873	
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 32,793			\$ 32,793	\$ *

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Warren Park Nursing Pavilion# 0036079Report Period Beginning: 01/01/04Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V		\$			\$	\$	15
16	V	10 MEDICAL SUPPLIES	27,453	LINCOLN MEDICAL SUPPLIES, INC.	100.00%	22,289	(5,164)	16
17	V	39 ANCILLARY EXPENSE	624	LINCOLN MEDICAL SUPPLIES, INC.	100.00%	507	(117)	17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 28,077			\$ 22,796	\$ * (5,281)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Warren Park Nursing Pavilion# 0036079Report Period Beginning: 01/01/04Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Warren Park Nursing Pavilion# 0036079Report Period Beginning: 01/01/04Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Warren Park Nursing Pavilion# 0036079Report Period Beginning: 01/01/04Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Warren Park Nursing Pavilion# 0036079Report Period Beginning: 01/01/04Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 7

Facility Name & ID Number Warren Park Nursing Pavilion # 0036079 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Marshall Mauer	Owner	Administrative	6.30%	See Attached	3.01	7.53%	Alloc. Dynam	\$ 12,793	17-7	1
2	Maury Aaron	Owner	Administrative	19.69%	See Attached	3.33	6.66%	Alloc. Dynam	14,156	17-7	2
3	Sharon Aaron	Relative	Clerical	0%	See Attached	3.01	7.53%	Alloc. Dynam	5,262	21-7	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 32,211		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME.
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Warren Park Nursing Pavilion # 0036079 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Warren Park Nursing Pavilion # 0036079 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization DYNAMIC HEALTH CARE CONS.
 Street Address 3359 W. MAIN STREET
 City / State / Zip Code SKOKIE, IL. 60076
 Phone Number (847) 679-8219
 Fax Number (847) 679-7377

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5 UTILITIES	PATIENT DAYS	427,864	12	\$ 9,658	\$	31,823	\$ 718	1
2	6 REPAIRS & MAINT.	PATIENT DAYS	427,864	12	19,683		31,823	1,464	2
3	19 PROFESSIONAL FEES	PATIENT DAYS	427,864	12	19,431		31,823	1,445	3
4	20 DUES AND SUBSCRIPTIONS	PATIENT DAYS	427,864	12	5,469		31,823	407	4
5	21 CLERICAL & GENERAL	PATIENT DAYS	427,864	12	405,253	290,672	31,823	30,141	5
6	24 SEMINARS AND TRAVEL	PATIENT DAYS	427,864	12	5,616		31,823	418	6
7	26 INSURANCE	PATIENT DAYS	427,864	12	17,537		31,823	1,304	7
8	27 EMP.BEN. - GEN. ADMIN.	PATIENT DAYS	427,864	12	71,885		31,823	5,347	8
9	30 DEPRECIATION	PATIENT DAYS	427,864	12	32,025		31,823	2,382	9
10	32 INTEREST	PATIENT DAYS	427,864	12	27,646		31,823	2,056	10
11	33 REAL ESTATE TAXES	PATIENT DAYS	427,864	12	34,248		31,823	2,547	11
12	35 EQUIPMENT RENTAL	PATIENT DAYS	427,864	12	71,259		31,823	5,300	12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 719,710	\$ 290,672		\$ 53,529	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Warren Park Nursing Pavilion# 0036079

Report Period Beginning:

01/01/04Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization DYNAMIC HEALTH CARE CONS.Street Address 3359 W. MAIN STREETCity / State / Zip Code SKOKIE, IL. 60076Phone Number (847) 679-8219Fax Number (847) 679-7377

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	6	MAINT. CMP. - D. NEHMER	WGHTD. AVG. HOURS	40	9	65,436	65,436	3.33	5,449	1
2	17	ADMIN. CMP. - M. MAUER	WGHTD. AVG. HOURS	40	11	170,000	170,000	3.01	12,793	2
3	17	ADMIN. CMP. - M. AARON	WGHTD. AVG. HOURS	40	9	170,000	170,000	3.33	14,156	3
4	17	ADMIN. CMP. - F. AARON	WGHTD. AVG. HOURS	47	6	119,100	119,100			4
5	17	ADMIN. CMP. - S. GOLDSTEIN	WGHTD. AVG. HOURS	45	3	24,000	24,000	35.00	18,667	5
6	17	ADMIN. CMP. - S. KOPLIN	WGHTD. AVG. HOURS	40	7	72,815	72,815	4.51	8,208	6
7	17	ADMIN. CMP. - D. MAGAFAS	WGHTD. AVG. HOURS	45	9	80,395	80,395	3.75	6,698	7
8	17	ADMIN. CMP. - S. LEVY	WGHTD. AVG. HOURS	45	11	152,350	152,350	3.39	11,468	8
9	17	ADMIN. CMP. - HOWARD ALT	WGHTD. AVG. HOURS	40	1	12,000	12,000			9
10	17	ADMIN. CMP. - NON-OWNER	WGHTD. AVG. HOURS	45	9	164,490	164,490	3.75	13,704	10
11	21	CLERICAL CMP. - S. AARON	WGHTD. AVG. HOURS	40	11	69,932	69,932	3.01	5,262	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 1,100,518	\$ 1,100,517		\$ 96,405	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Warren Park Nursing Pavilion# 0036079

Report Period Beginning:

01/01/04Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization DYNAMIC HEALTH CARE CONS.Street Address 3359 W. MAIN STREETCity / State / Zip Code SKOKIE, IL. 60076Phone Number (847) 679-8219Fax Number (847) 679-7377

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	7	EMP. BEN.- D. NEHMER	WGHTD. AVG. HOURS	40	9	5,508	3.33	459	1
2	27	EMP. BEN.- M. MAUER	WGHTD. AVG. HOURS	40	11	13,783	3.01	1,037	2
3	27	EMP. BEN.- M. AARON	WGHTD. AVG. HOURS	40	9	18,779	3.33	1,564	3
4	27	EMP. BEN.- F. AARON	WGHTD. AVG. HOURS	47	6	34,154			4
5	27	EMP. BEN.- S. GOLDSTEIN	WGHTD. AVG. HOURS	45	3	25,404	35.00	19,758	5
6	27	EMP. BEN.- S. KOPLIN	WGHTD. AVG. HOURS	40	7	21,655	4.51	2,441	6
7	27	EMP. BEN.- D. MAGAFAS	WGHTD. AVG. HOURS	45	9	7,575	3.75	631	7
8	27	EMP. BEN.- S. LEVY	WGHTD. AVG. HOURS	45	11	21,295	3.39	1,603	8
9	27	EMP. BEN.- HOWARD ALTER	WGHTD. AVG. HOURS	40	1	1,244			9
10	27	EMP. BEN.- NON-OWNER	WGHTD. AVG. HOURS	45	9	24,475	3.75	2,039	10
11	27	EMP. BEN. - S. AARON	WGHTD. AVG. HOURS	40	11	12,038	3.01	906	11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	185,910	\$	30,438	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Warren Park Nursing Pavilion# 0036079

Report Period Beginning:

01/01/04Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization DYNAMIC REHAB CONSULTANTS, L.L.C.
 Street Address 3359 W. MAIN STREET
 City / State / Zip Code SKOKIE, IL. 60076
 Phone Number (847) 679-8219
 Fax Number (847) 679-7377

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	<u>10A</u> THERAPY	<u>DIRECT ALLOCATION</u>						5,600	1
2	<u>19</u> PROFESSIONAL FEES	<u>DIRECT ALLOCATION</u>						2,320	2
3	<u>22</u> EMPLOYEE BENEFITS	<u>DIRECT ALLOCATION</u>							3
4	<u>39</u> ANCILLARY SERVICES	<u>DIRECT ALLOCATION</u>						24,873	4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$ 32,793	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Warren Park Nursing Pavilion # 0036079 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization LINCOLN MEDICAL SUPPLIES, INC.
 Street Address 3359 W. MAIN STREET
 City / State / Zip Code SKOKIE, IL. 60076
 Phone Number (847) 679-8219
 Fax Number (847) 679-7377

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1									1
2	10 MEDICAL SUPPLIES	DIRECT ALLOCATION						22,289	2
3	39 ANCILLARY EXPENSE	DIRECT ALLOCATION						507	3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$ 22,796	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Warren Park Nursing Pavilion# 0036079

Report Period Beginning:

01/01/04Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Warren Park Nursing Pavilion # 0036079 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Warren Park Nursing Pavilion # 0036079 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Warren Park Nursing Pavilion # 0036079 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	Devon Bank		X	Mortgage		6/1/95	\$		\$ 1,588,546			\$ 168,487	1
2	MB Financial Bank		X	Note Payable					98,000			25,317	2
3													3
4													4
5	See Supplemental Schedule												5
	Working Capital												
6	MB Financial Bank		X	Line Of Credit				700,000	446,457			7,303	6
7	Insurance		X					97,527				2,334	7
8	See Supplemental Schedule											5,845	8
9	TOTAL Facility Related						\$ 797,527	\$ 2,133,003			\$ 209,286	9	
	B. Non-Facility Related*												
10	Interest Income		X									(26,255)	10
11													11
12													12
13	See Supplemental Schedule												13
14	TOTAL Non-Facility Related						\$					\$ (26,255)	14
15	TOTALS (line 9+line14)						\$ 797,527	\$ 2,133,003			\$ 183,032	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A Line # N/A

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.) SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1							\$	\$			\$	1	
2												2	
3												3	
4												4	
5												5	
6												6	
7	TOTAL Long-Term											7	
	Working Capital												
8	MB Financial Bank		X	Working Capital			\$	\$			\$	3,789	8
9	Allocated From Dynamic		X									2,056	9
10													10
11													11
12													12
13													13
14	TOTAL Working Capital											5,845	14
	B. Non-Facility Related*												
15							\$	\$			\$		15
16													16
17													17
18													18
19													19
20	TOTAL Non-Facility Related												20

- * Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.) SEE ACCOUNTANTS' COMPILATION REPORT
- ** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

Facility Name & ID Number **Warren Park Nursing Pavilion**# **0036079** Report Period Beginning: **01/01/04** Ending: **12/31/04****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		
1. Real Estate Tax accrual used on 2003 report.			\$	127,000 1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$	113,796 2
3. Under or (over) accrual (line 2 minus line 1).			\$	(13,204) 3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	117,000 4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$	4,188 5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	107,984 7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	1999	120,343	8	
	2000	119,923	9	
	2001	123,042	10	
	2002	124,421	11	
	2003	114,549	12	
2004 Accrual = 2003 R/E Tax \$114,549 X 1.02 = \$117,000				
Allocated Dynamic Healthcare \$2,250.74				
				13 FROM R. E. TAX STATEMENT FOR 2003 \$ 13
				14 PLUS APPEAL COST FROM LINE 5 \$ 14
				15 LESS REFUND FROM LINE 6 \$ 15
				16 AMOUNT TO USE FOR RATE CALCULATION \$ 16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Warren Park Nursing Pavilion COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0036079

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847)236-1111 FAX #: (847)236-1155

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>11-31-302-043-0000</u>	<u>Long Term Care Property</u>	\$ <u>69,081.93</u>	\$ <u>69,081.93</u>
2. <u>11-31-302-008-0000</u>	<u>Long Term Care Property</u>	\$ <u>45,466.96</u>	\$ <u>45,466.96</u>
3. <u>10-23-404-059-0000</u>	<u>Home Office</u>	\$ <u>30,621.49</u>	\$ <u>2,250.74</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>145,170.38</u></u>	\$ <u><u>116,799.63</u></u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Warren Park Nursing Pavilion COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0036079

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847)236-1111 FAX #: (847)236-1155

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
2.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
3.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
4.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
5.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
6.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
7.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
8.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
9.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
10.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
		TOTALS	\$ <u> </u>	\$ <u> </u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

A. Square Feet: 43,400

B. General Construction Type: Exterior Brick Frame _____ Number of Stories 3

C. Does the Operating Entity? ☐ (a) Own the Facility ☒ (b) Rent from a Related Organization. ☐ (c) Rent from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? ☒ (a) Own the Equipment ☒ (b) Rent equipment from a Related Organization. ☒ (c) Rent equipment from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).
None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? ☐ YES ☒ NO
 If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
 3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
 (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>		<u>1985</u>	<u>\$ 158,750</u>	1
2					2
3	TOTALS			<u>\$ 158,750</u>	3

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various		1990		177,699		20	8,885	8,885	129,342	9
10	Various		1991		40,276		20	2,014	2,014	27,140	10
11	Various		1992		26,271		20	1,314	1,314	16,755	11
12	Various		1993		39,480		20	1,969	(1,969)	22,096	12
13	Various		1994		61,455		20	3,074	3,074	31,697	13
14	Various		1995		53,672		20	2,685	2,685	25,890	14
15	Various		1996		5,720		20	286	286	2,490	15
16	Various		1997		31,153		20	1,558	1,558	11,923	16
17	Various		1998		142,888		20	7,149	7,149	45,995	17
18	Various		1999		22,019		20	1,103	1,103	6,012	18
19	Various		2000		160,109		20	7,883	7,883	35,762	19
20								-		-	20
21								-		-	21
22								-		-	22
23								-		-	23
24								-		-	24
25								-		-	25
26								-		-	26
27								-		-	27
28								-		-	28
29								-		-	29
30								-		-	30
31								-		-	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12-BLDG & 12A-BLDG)		2,698,750	69,199		134,938	65,739	1,293,156	67
68	Related Party Allocations (Pages 12-REP & 12A-REP)		32,993	846		943	97	10,683	68
69	Financial Statement Depreciation			40,380			(40,380)		69
70	TOTAL (lines 4 thru 69)		\$ 3,492,485	\$ 110,425		\$ 173,801	\$ 59,438	\$ 1,658,941	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 3,492,485	\$ 110,425		\$ 173,801	\$ 63,376	\$ 1,658,941	1
2	Installation Of Outl	2001	7,175		20	359	359	1,375	2
3	Elevator Repair	2001	1,125		20	56	56	202	3
4	Draperies For Reside	2001	675		20	34	34	118	4
5	Tile	2001	1,139		20	57	57	204	5
6	Wiring On Ac Unit	2001	15,110		20	1,511	1,511	4,785	6
7	Cabinets	2001	10,150		20	1,015	1,015	3,214	7
8	Roof Repairs	2001	3,909		20	391	391	1,238	8
9	Wallpaper	2001	532		20	53	53	168	9
10	Sprinkler System	2001	923		20	24	24	94	10
11	Fire Alarm Repair	2001	709		20	18	18	70	11
12	Electrical Work	2001	625		20	16	16	55	12
13	Fire Alarm Repair	2001	533		20	53	53	178	13
14	Kithchen Ventilator	2001	752		20	19	19	65	14
15	Fire Repair	2001	1,215		20	122	122	395	15
16	Telephone System	2002	10,122		20	1,012	1,012	2,193	16
17	Sewer Pipe	2002	3,100		20	310	310	930	17
18	Chimenv Reconstruct	2002	1,350		20	135	135	304	18
19	Electrical Outlet Installation	2002	1,800		20	180	180	375	19
20	Removal Of Trees	2002	1,800		20	180	180	450	20
21	Glass Installation	2002	1,161		20	116	116	339	21
22	Install Emergency Light	2002	1,149		20	115	115	278	22
23	Patient Monitoring System	2003	14,634		20	1,463	1,463	2,317	23
24	Pagers And Watcher For Monitoring System	2003	830		20	83	83	166	24
25	Circuit For New Electric Stove	2003	850		20	85	85	142	25
26	Dedicated Circuit For Copier	2003	650		20	65	65	108	26
27	Security Cameras And Monitors	2003	2,355		20	236	236	334	27
28	Centrifical Roof Exhauster	2003	515		20	51	51	73	28
29	2 Centrifical Roof Exhausters	2003	1,054		20	105	105	149	29
30	Door Alarm	2003	695		20	70	70	87	30
31	Cameras, Etc	2003	1,175		20	118	118	137	31
32	Repair Cooler	2003	521		20	26	26	46	32
33	Building Material	2003	958		20	48	48	88	33
34	TOTAL (lines 1 thru 33)		\$ 3,581,776	\$ 110,425		\$ 181,927	\$ 71,502	\$ 1,679,618	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)								
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.								
1	2	3	4	5	6	7	8	9
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward	\$ 3,581,776	\$ 110,425		\$ 181,927	\$ 71,502	\$ 1,679,618	1
2	Sprinkler Heads, Splash Guards	2003 975		20 49		49	85	2
3	Rotary, Hinge Prep, Lite Kit, Glass	2003 1,241		20 62		62	109	3
4	Thermostat, Clean Cond. Unit	2003 545		20 27		27	43	4
5	Pump, Motor, Fan Blade	2003 786		20 39		39	62	5
6	Emergency Lights, Battery	2003 1,389		20 69		69	98	6
7	Water Heater	2004 5,765		20 336		336	336	7
8	Handicap Ramp In Entrance	2004 6,626		20 331		331	331	8
9	Pine Roofing - Roof Repairs	2004 2,405		20 20		20	20	9
10	Install Sprinkler Heads	2004 1,176		20 29		29	29	10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 3,602,684	\$ 110,425		\$ 182,889	\$ 72,464	\$ 1,680,731	34

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 3,602,684	\$ 110,425		\$ 182,889	\$ 72,464	\$ 1,680,731	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,602,684	\$ 110,425		\$ 182,889	\$ 72,464	\$ 1,680,731	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 3,602,684	\$ 110,425		\$ 182,889	\$ 72,464	\$ 1,680,731	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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19									19
20									20
21									21
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,602,684	\$ 110,425		\$ 182,889	\$ 72,464	\$ 1,680,731	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		\$ 3,602,684	\$ 110,425		\$ 182,889	\$ 72,464	\$ 1,680,731	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,602,684	\$ 110,425		\$ 182,889	\$ 72,464	\$ 1,680,731	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)									
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.									
1	2	3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		\$ 3,602,684	\$ 110,425		\$ 182,889	\$ 72,464	\$ 1,680,731	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,602,684	\$ 110,425		\$ 182,889	\$ 72,464	\$ 1,680,731	34

XI. OWNERSHIP COSTS (continued)									
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.									
1	2	3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		\$ 3,602,684	\$ 110,425		\$ 182,889	\$ 72,464	\$ 1,680,731	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,602,684	\$ 110,425		\$ 182,889	\$ 72,464	\$ 1,680,731	34

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1 Totals from Page 12H, Carried Forward		\$ 3,602,684	\$ 110,425		\$ 182,889	\$ 72,464	\$ 1,680,731		1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34 TOTAL (lines 1 thru 33)		\$ 3,602,684	\$ 110,425		\$ 182,889	\$ 72,464	\$ 1,680,731		34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)									
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.									
1	2	3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		\$ 3,602,684	\$ 110,425		\$ 182,889	\$ 72,464	\$ 1,680,731	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,602,684	\$ 110,425		\$ 182,889	\$ 72,464	\$ 1,680,731	34

XI. OWNERSHIP COSTS (continued)									
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.									
1	2	3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12J, Carried Forward		\$ 3,602,684	\$ 110,425		\$ 182,889	\$ 72,464	\$ 1,680,731	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,602,684	\$ 110,425		\$ 182,889	\$ 72,464	\$ 1,680,731	34

XI. OWNERSHIP COSTS (continued)										
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.										
	1 Beds*	2 FOR OHF USE ONLY	3 Year Acquired	4 Year Constructed	5 Cost	6 Current Book Depreciation	7 Life in Years	8 Straight Line Depreciation	9 Adjustments	10 Accumulated Depreciation
4	127		1995		\$ 2,698,750	\$ 69,199	39	\$ 134,938	\$ 65,739	\$ 1,293,156
5										
6										
7										
8										
9	Improvement Type**									
10										
11										
12										
13										
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34										
35										
36										

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)									
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.									
1	2	3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
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59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 2,698,750	\$ 69,199		\$ 134,938	\$ 65,739	\$ 1,293,156	70

XI. OWNERSHIP COSTS (continued)											
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.											
	1		2	3	4	5	6	7	8	9	
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	Allocated From Dynamic		1993		\$ 32,993	\$ 846	39	\$ 943	\$ 97	\$ 10,683	4
5											5
6											6
7											7
8											8
9	Improvement Type**										9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
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21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)									
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.									
1	2	3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
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58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 32,993	\$ 846		\$ 943	\$ 97	\$ 10,683	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 154,608	\$ 366	\$ 15,612	\$ 15,246	10	\$ 94,375	71
72	Current Year Purchases	8,732	692	900	208	10	1,180	72
73	Fully Depreciated Assets	428,083				10	428,083	73
74								74
75	TOTALS	\$ 591,423	\$ 1,058	\$ 16,512	\$ 15,454		\$ 523,638	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		DODGE - MIDWAY	1993	\$ 21,583	\$	\$	\$	5	\$ 21,583	76
77		1999 Lexus RX300	2003	16,000		4,080	4,080	5	6,480	77
78		Allocated From Dynamic	2003	4,187	478	478		5	4,187	78
79										79
80	TOTALS			\$ 41,770	\$ 478	\$ 4,558	\$ 4,080		\$ 32,250	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 4,394,627	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 111,961	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 203,959	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 91,998	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,236,619	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

**

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

☐ YES ☐ NO

16. Rental Amount for movable equipment: \$ 5,831

Description: See Attached Schedule

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Allocated from Dynamic		\$	\$ 5,235	17
18					18
19					19
20					20
21	TOTAL		\$	\$ 5,235	21

10. Effective dates of current rental agreement:

Beginning

Ending

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2005 \$

13. /2006 \$

14. /2007 \$

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	2. CLASSROOM PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> COMMUNITY COLLEGE <input type="checkbox"/> HOURS PER AIDE _____	3. CLINICAL PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> HOURS PER AIDE _____
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		1		2	3	4
		Facility				
		Drop-outs	Completed	Contract	Total	
1	Community College Tuition	\$	\$	\$	\$	
2	Books and Supplies					
3	Classroom Wages (a)					
4	Clinical Wages (b)					
5	In-House Trainer Wages (c)					
6	Transportation					
7	Contractual Payments					
8	Nurse Aide Competency Tests					
9	TOTALS	\$	\$	\$	\$	
10	SUM OF line 9, col. 1 and 2 (e)	\$				

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$ _____

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
 (c) For in-house training programs only. Do not include fringe benefits.
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.
SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 13,470	\$		\$ 13,470	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			1,453			1,453	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			14,614			14,614	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 03	# of prescrpts			104	29,338		29,442	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See Supplemental						13,726		13,726	13
14	TOTAL			\$		\$ 29,641	\$ 43,064		\$ 72,705	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 527	\$ 1,204	1
2	Cash-Patient Deposits	63,972	63,972	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	587,496	597,496	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	34,444	34,444	6
7	Other Prepaid Expenses	4,323	4,323	7
8	Accounts Receivable (owners or related parties)	505,591	593,197	8
9	Other(specify): See Attached Schedule	40,226	80,033	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,236,579	\$ 1,374,669	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		158,750	13
14	Buildings, at Historical Cost		2,698,750	14
15	Leasehold Improvements, at Historical Cost	802,984	1,120,484	15
16	Equipment, at Historical Cost	292,974	292,974	16
17	Accumulated Depreciation (book methods)	(467,344)	(1,445,117)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	7,000	7,000	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(7,000)	(7,000)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):		(216,344)	22
23	Other(specify): See Attached Schedule	216,439	216,439	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 845,053	\$ 2,825,936	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,081,632	\$ 4,200,605	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 290,560	\$ 290,559	26
27	Officer's Accounts Payable	529,200	529,200	27
28	Accounts Payable-Patient Deposits	63,972	63,972	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	102,124	102,124	30
31	Accrued Taxes Payable (excluding real estate taxes)	3,614	3,614	31
32	Accrued Real Estate Taxes(Sch.IX-B)	117,000	117,000	32
33	Accrued Interest Payable	1,020	131,258	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	4,274	4,274	35
	Other Current Liabilities(specify):			
36	See Attached Schedule	16,467	16,467	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,128,231	\$ 1,258,468	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	544,457	2,133,003	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 544,457	\$ 2,133,003	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,672,688	\$ 3,391,471	46
47	TOTAL EQUITY (page 18, line 24)	\$ 408,944	\$ 809,134	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,081,632	\$ 4,200,605	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 444,563	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 444,563	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(35,619)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (35,619)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 408,944	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

VII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 3,472,403	1
2	Discounts and Allowances for all Levels	(174,172)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,298,231	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	120,400	6
7	Oxygen	6,059	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 126,459	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	41,621	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	2,842	19
20	Radiology and X-Ray	83	20
21	Other Medical Services	17,741	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 62,287	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	26,255	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 26,255	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	2,657	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 2,657	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,515,889	30

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	719,715	31
32	Health Care	1,154,161	32
33	General Administration	953,749	33
	B. Capital Expense		
34	Ownership	566,407	34
	C. Ancillary Expense		
35	Special Cost Centers	87,752	35
36	Provider Participation Fee	69,724	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,551,508	40
41	Income before Income Taxes (line 30 minus line 40)**	(35,619)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (35,619)	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? Cash Basis If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number **Warren Park Nursing Pavilion**# **0036079**Report Period Beginning: **01/01/04**

Ending:

12/31/04**XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)**

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,432	1,456	\$ 37,271	\$ 25.59	1
2	Assistant Director of Nursing	3,021	3,140	70,434	22.43	2
3	Registered Nurses	8,496	8,948	185,304	20.71	3
4	Licensed Practical Nurses	8,368	8,913	164,794	18.49	4
5	Nurse Aides & Orderlies	41,600	44,550	377,781	8.48	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,044	2,138	31,754	14.85	9
10	Activity Assistants	3,923	4,029	28,930	7.18	10
11	Social Service Workers	6,473	7,192	91,336	12.70	11
12	Dietician					12
13	Food Service Supervisor	1,988	2,046	33,999	16.62	13
14	Head Cook	8,733	9,504	88,955	9.36	14
15	Cook Helpers/Assistants	9,124	9,888	75,245	7.61	15
16	Dishwashers					16
17	Maintenance Workers	1,577	1,746	29,292	16.78	17
18	Housekeepers	10,968	11,900	92,821	7.80	18
19	Laundry	4,926	5,367	37,732	7.03	19
20	Administrator	2,100	2,151	58,576	27.23	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,071	4,286	52,375	12.22	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	227	227	3,132	13.79	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	400	400	15,047	37.62	33
34	TOTAL (lines 1 - 33)	119,472	127,880	\$ 1,474,778 *	\$ 11.53	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	267	\$ 6,720	01-03	35
36	Medical Director	84	4,200	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	126	5,015	10-03	39
40	Physical Therapy Consultant	58	2,008	10a-03	40
41	Occupational Therapy Consultant	65	2,261	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	43	1,482	10a-03	43
44	Activity Consultant	52	2,044	11-03	44
45	Social Service Consultant	44	2,380	12-03	45
46	Other(specify) <u>Rehab Consultant</u>	58	2,320	10-03	46
47					47
48					48
49	TOTAL (lines 35 - 48)	797	\$ 28,430		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	1,413	\$ 54,401	10-03	50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	1,413	\$ 54,401		53

SEE ACCOUNTANTS' COMPILATION REPORT

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	% Ownership	Amount	Description		Amount	Description	Amount
Steven Goldstein	Administrator	0	\$ 58,576	Workers' Compensation Insurance		\$ 46,001	IDPH License Fee	\$
				Unemployment Compensation Insurance		19,838	Advertising: Employee Recruitment	3,231
				FICA Taxes		113,709	Health Care Worker Background Check (Indicate # of checks performed <u>11</u>)	130
				Employee Health Insurance		68,015	Illinois Association Of HCF	635
				Employee Meals		40,754	Licenses & Permits	4,114
				Illinois Municipal Retirement Fund (IMRF)*			IL Council On LTC	5,519
				Chicago Head Tax		3,912	Allocated From Dynamic	406
				Other Employee Benefits		4,128		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 58,576					
B. Administrative - Other							Less: Public Relations Expense	()
Description			Amount				Non-allowable advertising	()
Management Fees-Dynamic			\$ 36,000				Yellow page advertising	()
				TOTAL (agree to Schedule V, line 22, col.8)	\$	296,357	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 14,036
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 36,000	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
C. Professional Services				Description	Line #	Amount	Description	Amount
Vendor/Payee	Type		Amount				Out-of-State Travel	\$
Frost, Ruttenberg & Rothblatt	Accounting		\$ 12,708					
Econocare, Inc	Purchasing Consultant		2,286				In-State Travel	
Dynamic Healthcare	Accounting		857					
Personnel Planners	Unemployment Consult.		960				Seminar Expense	1,622
S&S Associates	Geriatric Consulting		8,750				Allocated From Dynamic	418
Sachnoff & Weaver	Legal Fees		9,862					
Finkel, Martwick & Colson	Legal Fees		4,188				Entertainment Expense	()
Health Data System	Data Processing		3,760				(agree to Sch. V, line 24, col. 8)	
Dynamic Healthcare	Bookkeeping		256,900				TOTAL	\$ 2,040
Other Professional	Prior Period Adjustment		(563)					
Robinson & Associates	Computer Support		330					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$ 300,038	TOTAL		\$		

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

****See instructions.**

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

1		2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **Warren Park Nursing Pavilion**

STATE OF ILLINOIS

0036079

Report Period Beginning:

01/01/04

Ending:

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12/31/04

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN, LPN, NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. IL Council - \$1833.92
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 941 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 69,724
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? N/A
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 40,754 Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 100% in 14
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? No
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.